PREVENTING CHILD DEATHS

Report and Recommendations on the Review of 2010 Child Deaths

Mahoning County Child Fatality Review Board

The mission of the Mahoning County Child Fatality Review Board is to decrease the incidence of preventable fetal and child deaths by:

- *Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities that serve families and children*
- *Maintaining a comprehensive database of all child deaths that occur in Mahoning County in order to develop an understanding of the causes and incidences of those deaths*
- *Recommending local services and program changes to the groups, professions, agencies, or entities that serve families and children that might prevent fetal and child deaths*
- *Advising the Ohio Department of Health of aggregate data trends and patterns concerning child deaths*

Established by the Ohio General Assembly in July 2000, the Child Fatality Review (CFR) Program in Ohio works to reduce the incidence of preventable child deaths. Each county is required to establish a CFR Board that must review the deaths of children under 18 years of age residing in that county. In Mahoning County, the CFR Board is coordinated by the Mahoning County District Board of Health. Mandated members of the board include the county coroner, a chief of police or sheriff, the children services agency, a public health official, a representative of the board of alcohol, drug addiction, and mental health services boards, a physician, and additional members are included as necessary for review. The Mahoning County CFR Board reviews all child death in the county but a more thorough review is prepared and discussed at quarterly review meetings on all child deaths that occur under the following conditions:

- A death which has been investigated by the coroner, which includes any death unattended by a physician and a death due to an injury, either intentional or unintentional
- When a review is requested by any Child Fatality Review Board participant

Dedication

This report reflects the work of many dedicated professionals in the community who have committed themselves to gaining a better understanding of how and why children die. Their work is driven by a desire to protect and improve the lives of young children. Each child's death represents a tragic loss for the family, as well as the community. We dedicate this report to the memory of these children and to their families. *(Ohio Child Fatality Review, 11th Annual Report, 2011).*

Key Findings of 2010 Child Deaths

In 2010, 38 child deaths occurred in Mahoning County. Of the child deaths, 60.5% were among white children, 36.8% were black, and 2.6% were Asian. Natural deaths accounted for the majority of death (76.3%), accidental (unintentional injuries) deaths accounted for 14%, homicide accounted for 7.9% of the deaths, and one death (2.6%) reviewed was of an undetermined manner.

Prematurity was the most frequent medical cause of death accounting for 55.3% of all the child deaths. In 2009, deaths due to prematurity accounted for only 36.8% of the deaths. Five others died due to **birth defects**, which is down by approximately half from 2009. Three children died from **homicide** and two children died from **asphyxia in a sleep environment.** One child in Mahoning County died from each of the following: Sudden Infant Death Syndrome (SIDS), drowning, prescription drug poisoning, cancer, motor vehicle crash, and pneumonia. A table summarizing all 38 child deaths in 2010 can be found on page 5 of this report. We will focus on two of these deaths in this report.

In April of 2010, a mother and her one year old daughter laid down on a bed to take a nap. She placed her 3-month old infant at the bottom of the bed on his stomach on top of the comforter. The life-less infant was discovered, face down on the bed, by the father a couple of hours later. EMS was summoned; however, the infant had already expired. The coroner ruled the death due to positional asphyxia. There was no crib in the home and the infant's normal sleeping place was a car seat.

Co-sleeping, the practice of one person sharing the same bed with another, can lead to suffocation in infants when the other person sharing the bed falls asleep. An infant can suffocate when they become trapped between couch cushions or between a bed and a wall or when the person unknowingly rolls over on top of the infant. Unconsciousness can happen in less than a minute and the death of the infant can result within a few minutes from lack of oxygen. The Child Fatality Review Board urges health care and social service providers to continue to reinforce the "Back to Sleep" and "ABC" (babies should sleep "Alone, on their Backs, in a Crib) messages with caregivers of infants. Sleep-related deaths like these still continue despite efforts by the community to help families provide a safe sleep environment. Promoting a safe sleep environment has been the Board's most often cited recommendation. According to *the Ohio Child Fatality Review, 11th Annual Report*, "For the second year since CFR began collecting data, more children died of asphyxia than vehicular crashes. Seven percent of all deaths reviewed were from asphyxia, including suffocation, strangulation and choking. Half of the deaths were children less than 1 year of age, many of which occurred in a sleep environment."

Infant Safe Sleep Practices (based on American Academy of Pediatrics Recommendations)

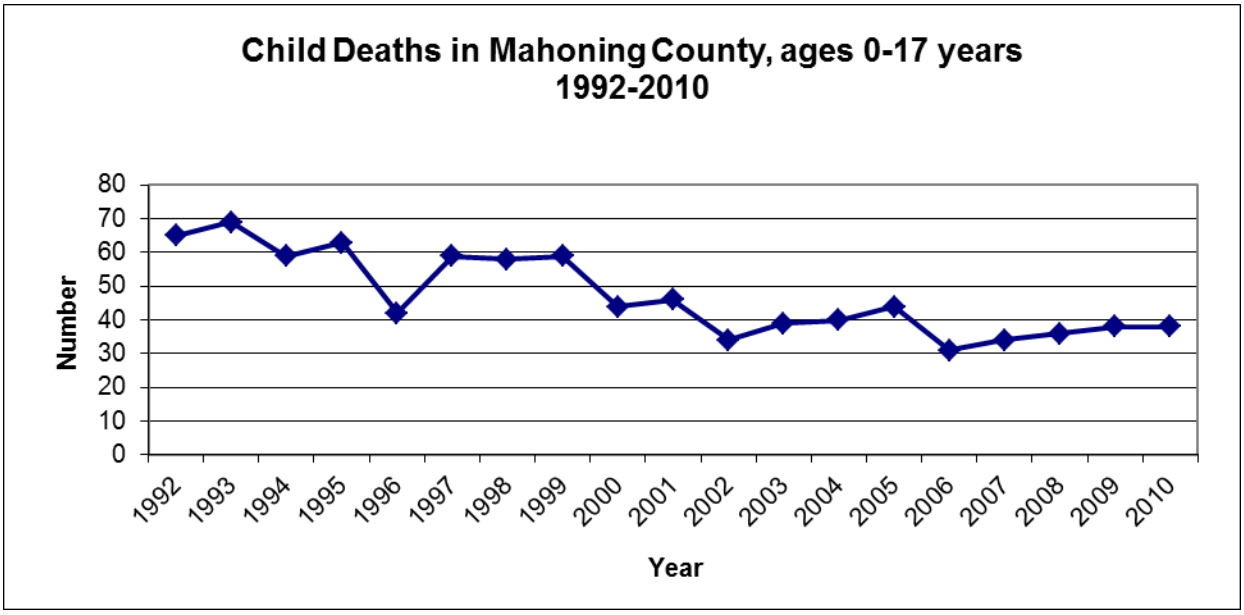
- Infants should be put to sleep on their backs only.
- Infants should sleep in a crib, bassinet, or portable crib/play yard with a firm mattress covered with a tight-fitting sheet. It should be free from toys, soft bedding, blankets, and pillows.
- They should sleep in the same room, but not the same bed, as the caregiver.
- Avoid smoking, drinking alcohol, and using illicit drugs during pregnancy and after birth.
- Offer a pacifier at nap and bed time.
- Breastfeeding is recommended as well as fully immunizing in accordance with recommendations.
- Avoid overheating by not over bundling and covering of the face and head.

In August 2010, a 17 year-old Youngstown youth was shot and killed. Several youth were gathered at a party on Youngstown's south side, when shots were fired. A witness then heard someone say, "Why you do that?!" The juveniles scattered and one victim remained lying on his back. The deceased was not the intended victim. Another juvenile was charged with his murder.

Homicide deaths is the number one cause of injury related deaths in Mahoning County. Since 2005, 25 children under the age of 18 lost their lives due to deliberate act, at the hands of someone else. The majority of these children were between the ages of 15 to 17 (48%), but an additional 24% were between the ages of 1-4 years. Homicide deaths to males and blacks were disproportionately high. The majority of these homicides were as a result of a shooting, whether or not the child was the intended victim. The children between 1-4 years of age died because of abuse (physical or neglect). There were also an additional 4 deaths in Mahoning County due to arson.

Trends in Child Deaths

To understand child fatalities in Mahoning County, it is important to examine trends over time. The following graph demonstrates that while there has been some variability in the numbers over time, there has been a notable decrease of child deaths since the high of 69 child deaths in 1993. Since 2006, the graph is showing a slight leveling. The number of child deaths in 2010 remains the same as in 2009.



According to the *Ohio Child Fatality Review, 11th Annual Report,* the following was noted after review of child deaths in Ohio during the time period of 2005 to 2009:

- The mortality rate has decreased from 69 deaths per 100,000 population in 2005 to 61 in 2009.
- The percentage of deaths from external causes (external causes of death are injuries, either unintentional or intentional damage to the body) due to vehicular crashes decreased from 29% to 23%.
- The percentage of deaths from external causes due to asphyxia has increased from 21% to 29%.
- 57% of the infant deaths due to external causes were due to asphyxia.
- Drowning was the leading external cause of death for children 1-4 years old.
- Vehicular crashes were the leading external cause of death for children older than 5 years old.

On the final page of this report you will find a table summarizing all Mahoning County child deaths from 2005 to 2010 by cause of death. Of note:

- Nearly 63% of the deaths were of infants less than 1 year of age.
- The top 5 causes of deaths to children under the age of 18 are:
    - Prematurity (40%)
    - Birth Defects (15.7%)
    - Homicide (11.3%)
    - SIDS and Sleep-Related Deaths (7.2%)
    - Motor Vehicle Crashes and Cancer (5.4% each).

Child Fatality Review Board Recommendations

Since its inception in 2000, the Mahoning County CFR Board has made yearly recommendations to prevent future child deaths. The past recommendations are highlighted below:

- Increased support for school-based adolescent suicide prevention programs. (2001, 2005)
- Promote a safe sleeping environment for infants. (2002, 2004, 2008, 2009, 2010)
- Strengthen graduated driver licensing for teens. (2001, 2003)
- Enforcement of firearms possession laws. (2003)
- Strengthen seat belt and child booster seat laws. (2003, 2009)
- Involve law enforcement agencies in the child death review process. (2001)
- Continue educational and enforcement initiatives to improve safety for motor vehicle passengers and new drivers. (2010)
- Educate on the importance of knowing ones family medical history so health risks are known and it aids in the early diagnosis of potential heart defects. (2010)

Acknowledgements

We wish to thank the local funeral homes, members of the Mahoning, Trumbull and Columbiana County Funeral Directors Association, and the Youngstown City Health District for providing the CFR Board with copies of child birth and death certificates.

We would also like to thank the members who serve on the CFR board of their many years of support and dedication. Members of the CFR Board have to step outside their personal comfort zones to examine all of the circumstances that lead to child deaths. We thank them for having the courage to use their professional expertise to work toward preventing future child deaths. Special thanks to Jan Baharis, from Compass Family and Community Services – Daybreak, who voluntarily gives of her time to organize the reports for our quarterly meetings and to Dr. Joseph Ohr and Rick Jamozik of the Mahoning County Coroner's Office, without whose support, our work would be much more difficult!

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Mahoning County Child Fatality Review Board reports may be found on the Mahoning County District Board of Health's website at http://www.mahoninghealth.org/Reports/AnnualReports.aspx.

Child Deaths in Mahoning County 2010

Ages

- 38 child deaths in 2010
  - 29 (76.3%) deaths were infants (birth up to 1 year)
    - 23 infant deaths (79.3%) were neonates (birth-28 days)
    - 6 infant deaths (20.7%) were post-neonates
  - 3 death (7.9%) was preschool-age (1-4 years)
  - 3 deaths (7.9%) was 5-9 years
  - 3 deaths (7.9%) were teens (15-17 years)

Residence

- 20 in Youngstown (52.6%)
- 4 in Boardman (10.5%)
- 3 in Austintown (7.9%)
- 2 in Campbell (5.3%)
- 2 in Canfield (5.3%)
- 1 in each Lake Milton, Lowellville, New Springfield, Poland, Salem, Sebring, and Struthers

Race

- 23 were white (60.5%); 14 were black (36.8%); 1 was Asian (2.6%)

Sex

- 20 were boys (52.6%); 18 were girls (47.4%)

Deaths by Age Group by Cause

Cause	0-1 Months	1-12 Months	1-4 Years	5-9 Years	10-14 Years	15-17 Years	Total
Prematurity	19	2					21
Birth Defects	3		1	1			5
SIDS		1					1
Cancer				1			1
Pneumonia		1					1
Drowning				1			1
Sleep Related/Asphyxia		2					2
Poisoning			1				1
Motor Vehicle						1	1
Homicide			1			2	3
Unknown	1						1
Total	**23**	**6**	**3**	**3**		**3**	**38**

Deaths by Age Group by Cause – 2005 to 2010

Cause	0-1 Months	1-12 Months	1-4 Years	5-9 Years	10-14 Years	15-17 Years	Total
Prematurity	79	10					89
Birth Defects	15	5	8	3	2	2	35
SIDS/Sleep Related	1	15					16
Cancer			2	3	6	1	12
Pneumonia	1	2					3
Pulmonary Embolism						2	2
Neurological				1			1
Heart Disease						1	1
Seizure			1			1	2
Infectious Disease	2	3	1				6
Drowning		1		1		1	3
Drug OD/Poisoning			1		1		2
Motor Vehicle		1	1	2	1	7	12
Fire					1		1
Choking				1			1
Electrocution					1		1
Other Accidents			1				1
Suicide					1	4	5
Homicide		2	6	3	2	12	25
Unknown	1	1	2				4
Total	**99**	**40**	**23**	**14**	**15**	**31**	**222**